		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033571

Facility Name: Allen Court

Address: 1650 E. Main St. (Number) Clinton (City) 61727 (Zip Code)

County: DeWitt

Telephone Number: (217) 935-8830 **Fax #** (217) 935-4452

IDPA ID Number: 37-1079626033

Date of Initial License for Current Owners: 05/17/88

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/01 to 09/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Tim Bledsoe
(Title) Director of Operations

Paid Preparer
(Signed) See Attached Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP
(Firm Name & Address) 117 East Main Street, Suite 210, P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,711	0		5,711	13
14	TOTALS	5,711			5,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.79%

D. How many bed-hold days during this year were paid by Public Aid?
56 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/17/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/24/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/02 Fiscal Year: 09/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 **Report Period Beginning:** 10/01/01 **Ending:** 09/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	37,170	2,816	2,640	42,626		42,626	18	42,644			1
2	Food Purchase		31,529		31,529	(857)	30,672		30,672			2
3	Housekeeping	19,401	2,848	190	22,439		22,439		22,439			3
4	Laundry		1,920		1,920		1,920		1,920			4
5	Heat and Other Utilities			13,969	13,969		13,969		13,969			5
6	Maintenance	5,017	4,577	5,738	15,332		15,332		15,332			6
7	Other (specify):*											7
8	**TOTAL General Services**	61,588	43,690	22,537	127,815	(857)	126,958	18	126,976			8
	B. Health Care and Programs											
9	Medical Director			300	300		300		300			9
10	Nursing and Medical Records	139,584	3,720	7,418	150,722		150,722		150,722			10
10a	Therapy			315	315		315		315			10a
11	Activities		1,663	798	2,461		2,461	(949)	1,512			11
12	Social Services			720	720		720		720			12
13	Nurse Aide Training	5,336			5,336		5,336		5,336			13
14	Program Transportation			539	539	746	1,285		1,285			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	144,920	5,383	10,090	160,393	746	161,139	(949)	160,190			16
	C. General Administration											
17	Administrative	18,667			18,667		18,667		18,667			17
18	Directors Fees							368	368			18
19	Professional Services			34,190	34,190		34,190	(4,086)	30,104			19
20	Dues, Fees, Subscriptions & Promotions			2,327	2,327		2,327	129	2,456			20
21	Clerical & General Office Expenses	11,076	1,754	6,519	19,349		19,349	1,105	20,454			21
22	Employee Benefits & Payroll Taxes			51,044	51,044	857	51,901	2,393	54,294			22
23	Inservice Training & Education			1,360	1,360		1,360	231	1,591			23
24	Travel and Seminar			1,552	1,552		1,552	652	2,204			24
25	Other Admin. Staff Transportation			1,491	1,491	(746)	745	293	1,038			25
26	Insurance-Prop.Liab.Malpractice			5,801	5,801		5,801	412	6,213			26
27	Other (specify):* **Attached Sch VIII**			346	346		346	(346)				27
28	**TOTAL General Administration**	29,743	1,754	104,630	136,127	111	136,238	1,151	137,389			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	236,251	50,827	137,257	424,335		424,335	220	424,555			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Allen Court #0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			19,563	19,563		19,563	(26)	19,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,292	22,292		22,292		22,292			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							110	110			34
35	Rent-Equipment & Vehicles			783	783		783		783			35
36	Other (specify):* Attached Sch VIII											36
37	**TOTAL Ownership**			42,638	42,638		42,638	84	42,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,511	34,511		34,511		34,511			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			34,511	34,511		34,511		34,511			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	236,251	50,827	214,406	501,484		501,484	304	501,788			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Allen Court

ID# 0033571

Report Period Beginning: 10/01/01

Ending: 09/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(423)	V-30		9
10	Interest and Other Investment Income		V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1)	V-27		24
25	Fund Raising, Advertising and Promotional		V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule IX	(1,294)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,718)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule See Att Sch III	2,022		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,022		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 304		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Allen Court # 0033571 **Report Period Beginning:** 10/01/01 **Ending:** 09/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Allen Court # 0033571 **Report Period Beginning:** 10/01/01 **Ending:** 09/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	See Attached Schedule I		None		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See Attached Schedules II & III								368	18-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 368		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Community Living Options, Inc.
Street Address: 239 South Cherry Street
City / State / Zip Code: Galesburg, IL 61401
Phone Number: (309) 343-7777
Fax Number: (309) 343-1469

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		See Attached Schedules II & III							17,601	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 17,601	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	Illinois Development		X	Refinance facility purchase	See Note (1)	2/15/95	500,000	260,085	3/1/2010	6.9800	22,292	2
3	Finance Authority											3
4		Note (1):Interest is paid semiannually. Principal is paid annually.										4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 500,000	$ 260,085			$ 22,292	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 500,000	$ 260,085			$ 22,292	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	N/A	8
	1998	N/A	9
	1999	N/A	10
	2000	N/A	11
	2001	N/A	12

The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Allen Court COUNTY DeWitt

FACILITY IDPH LICENSE NUMBER 0033571

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,050 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	49,200	1990	$ 22,692	1
2					2
3	TOTALS	49,200		$ 22,692	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1990	1988	$ 412,308	$ 14,167	30	$ 13,744	$ (423)	$ 169,509	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1988	10,000	667	15	667		8,241	9
10	Parking Lot, Sidewalks & Landscaping			1988	20,000	1,333	15	1,333		16,470	10
11	Carpeting			1996	6,280	897	7	897		5,382	11
12	A/C Condenser			1996	1,275	85	15	85		531	12
13	Siding			2001	2,876	176	15	176		176	13
14	Roof Repairs			2002	3,105	52	10	52		52	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 455,844	$ 17,377		$ 16,954	$ (423)	$ 200,361	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 47,041	$ 945	$ 945	$	5-15 yrs	$ 42,470	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Sch III)		397	397				74
75	TOTALS	$ 47,041	$ 1,342	$ 1,342	$		$ 42,470	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2001 Ford Van	2002	$ 19,847	$ 1,241	$ 1,241	$	4 yrs	$ 1,241	76
77										77
78										78
79										79
80	TOTALS			$ 19,847	$ 1,241	$ 1,241	$		$ 1,241	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 545,424	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,960	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,537	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (423)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 244,072	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Facility Owned

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ N/A
13.	/2004	$ N/A
14.	/2005	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A - Facility Owned
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 138

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		5,336		5,336
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,336	$	$ 5,336
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,336			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 149	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	95,992		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,550		6
7	Other Prepaid Expenses	13		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	1,087,766		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,193,470	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	468,536		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	66,888		16
17	Accumulated Depreciation (book methods)	(249,601)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule VII			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 295,823	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,489,293	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,273	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,961		30
31	Accrued Taxes Payable (excluding real estate taxes)	662		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,150		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 28,046	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	260,085		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 260,085	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 288,131	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,201,162	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,489,293	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,060,386	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,060,386	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	140,776	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 140,776	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,201,162	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 624,379	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 624,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,336	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,336	23
	D. Non-Operating Revenue		
24	Contributions	157	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 157	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Activity Fund Income**	949	28
28a	**Gain on Disposal of Equipment**	1,200	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,149	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 632,021	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	127,468	31
32	Health Care	160,393	32
33	General Administration	126,235	33
	B. Capital Expense		
34	Ownership	42,638	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,511	36
	D. Other Expenses (specify):		
37	**See Attached Schedule IV**		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 491,245	40
41	**Income before Income Taxes (line 30 minus line 40)****	140,776	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 140,776	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses			0		3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	11,703	12,583	111,237	8.84	5
6	Nurse Aide Trainees	698	698	5,336	7.64	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,870	4,161	36,823	8.85	15
16	Dishwashers					16
17	Maintenance Workers	472	502	5,017	9.99	17
18	Housekeepers	1,860	2,000	19,401	9.70	18
19	Laundry			0		19
20	Administrator	462	491	9,449	19.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,117	1,189	10,402	8.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,386	1,474	28,347	19.23	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attatched Schedule IV					33
34	TOTAL (lines 1 - 33)	21,568	23,098	$ 226,012 *	$ 9.78	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 2,640	1-3	35
36	Medical Director	***	300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	***	2,795	10-3	38
39	Pharmacist Consultant	***	440	10-3	39
40	Physical Therapy Consultant	***		10a-3	40
41	Occupational Therapy Consultant	***		10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	315	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	***	720	12-3	45
46	Other(specify) Dental Consultant	***	623	10-3	46
47	Psychological Consultant	***	3,560	10-3	47
48	***=Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 11,393		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Laura Kelly	Adminstrator	None	9,449
See Attached Schedule III	Indirect Costs	N/A	9,218
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 18,667

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	$ 28,850
Community Living Options, Inc.	Support Services	5,340
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,190

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,060
Unemployment Compensation Insurance	
FICA Taxes	16,386
Employee Health Insurance	23,599
Employee Meals	857
Illinois Municipal Retirement Fund (IMRF)*	
401(k) and Other Employee Benefits	4,999
Indirect Costs-See Attached Schedule III	2,393
TOTAL (agree to Schedule V, line 22, col.8)	$ 54,294

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	815
Health Care Worker Background Check	83
(Indicate # of checks performed 6)	
IHCA Dues	524
Subscriptions	825
Advertising - Promotion	0
Other Licenses and Fees	80
Indirect Costs- See Attached Schedule III	129
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,456

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	1,344
travel voucher)	
Seminar Expense	208
Less: Non-allowable out-of-state travel	0
Indirect Costs- See Attached Sch III	652
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,204

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Allen Court # 0033571 Report Period Beginning: 10/01/01 Ending: 09/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Page 21, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes- IHCA Dues** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,511**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **857** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

FACILITY NAME: Allen Court **YEAR ENDED:** 09/30/02

COST REPORT GROUPINGS
DATA INPUT SHEET

Cost Center	Cost Type	Grouping Code	$ Amount
Dietary	Labor	1-1	36,823
Dietary	Supplies	1-2	2,816
Dietary	Other	1-3	2,640
Nursing	Labor	10-1	144,920
Nursing	Supplies	10-2	3,720
Nursing	Other	10-3	7,418
Therapy	Other	10A-3	315
Activities	Labor	11-1	
Activities	Supplies	11-2	1,663
Activities	Other	11-3	798
SocialServices	Labor	12-1	
SocialServices	Other	12-3	720
NurseAideTrng	Labor	13-1	
NurseAideTrng	Supplies	13-2	
NurseAideTrng	Other	13-3	
ProgramTransp	Other	14-3	539
Administrative	Labor	17-1	9,449
Directors Fees	Other	18-3	0
Prof. Services	Other	19-3	34,190
FoodPurchase	Supplies	2-2	31,529
Fees,Subs&Promo	Other	20-3	2,327
Clerical&GO	Labor	21-1	10,402
Clerical&GO	Supplies	21-2	1,754
Clerical&GO	Other	21-3	6,519
EmployeeBen	Other	22-3	51,044
Inservice Training	Other	23-3	1,360
Travel	Other	24-3	1,344
Seminar	Other	24-3a	208
Admin Staff Transp	Other	25-3	1,491
Insurance	Other	26-3	5,801
Bad Debts	Other	27-3	1
Lobbying	Other	27-3a	345
Housekeeping	Labor	3-1	19,401
Housekeeping	Supplies	3-2	2,848
Housekeeping	Other	3-3	190
Depreciation	Other	30-3	19,563
Amort of Pre-Op	Other	31-3	0
Interest	Other	32-3	22,292
RealEstateTax	Other	33-3	0
Rent-Facility	Other	34-3	0
Rent-Equip&Vehicles	Other	35-3	783
Amortization	Other	36-3	0
Ancillary	Labor	39-1	
Ancillary	Other	39-3	
Laundry	Labor	4-1	0
Laundry	Supplies	4-2	1,920
Vending	Other	41-3	
ProvParticFee	Other	42-3	34,511
OutpatientCare	Labor	43-1	
OutpatientCare	Other	43-3	
Utilities	Other	5-3	13,969
Maintenance	Labor	6-1	5,017
Maintenance	Supplies	6-2	4,577
Maintenance	Other	6-3	5,738
MedicalDirector	Other	9-3	300

Balance Sheet	Grouping Code	$ Amount
Cash	A1	149
Patient Deposits	A2	
Accounts Receivable	A3	95,992
Prepaid Insurance	A6	9,550
Other Prepaid Exp	A7	13
Interdivision Receivable	A9	1,087,766
Interest Receivable	A9a	
Long-Term Investments	B12	
Land	B13	10,000
Buildings	B14	468,536
Leasehold Improve	B15	0
Equipment	B16	66,888
Accum Depreciation	B17	(249,601)
Deferred Maintenance	B18	0
Org & Pre-Op Costs	B19	0
Accum Amortization	B20	0
Restricted Funds	B21	
Loan Financing Costs	B23a	
Leasehold Deposit	B23b	0
Total Assets		1,489,293
Accounts Payable	C26	9,273
A/P-Patient Deposits	C28	
Accrued Salaries	C30	15,961
Accrued Taxes	C31	662
AccrRealEstateTax	C32	0
Accrued Interest	C33	2,150
Interdivision Payable	C36	0
Other Current Liab	C37	0
Mortgage Payable	D40	260,085
Security Deposits	D44	
Retained Earnings	D47	1,060,386
Total Liab & Equity		1,348,517
Net Income(Loss)		**140,776**
Ending RE		**1,201,162**
Gross Revenue	R1	624,379
NurseAideTrngReimb	R11	5,336
Vending	R12	
Barber & Beauty	R13	
Non-Patient Meals	R14	
Telephone & TV	R15	
Non-Patient Supplies	R18	
Contributions	R24	157
Interest	R25	0
Activity Fund Income	R28	949
Durable Med Equip	R28a	0
Gain(loss)-equipment	R28b	1,200
Outpatient Services	R5	0
Therapy	R6	
Oxygen	R7	
Total Revenue		632,021
Total Costs		491,245
Net Income(Loss)		**140,776**
Input Error (s/b -0-)		**0**

FACILITY NAME: Allen Court **YEAR ENDED:** 09/30/02

OTHER INFORMATION DATA INPUT SHEET

EMPLOYEE MEALS (3%) 28,581 857
(Grouping Code 2-2 a/c # 5100 - Food Supplies)

DIAPER EXPENSE 0
(Grouping Code 10-2 a/c # 4115 - Incontinence)

VEHICLE EXPENSE 1,439
(Grouping Code 25-3 a/c # 9305)

PRIOR YEAR ENDING EQUITY 1,060,386 0
(page 17, line 47) pg 17 vs GL variance

CENSUS INFORMATION (days)

IDPA	5,711
IDPABH	56
P.P.	0
PPBH	0
Total w/BH	5,767

NURSING WAGES (grouping code 10-1)

a/c #		
2000	116,573	
2005	28,347	
4000	0	
4010	0	
Total	144,920	0 over(under) variance

NON-ALLOWABLE TRAVEL 0

PROPERTY & EQUIPMENT

	Cost Per Books	IDPA Adjustment	Accum Depr Per Books	Accum IDPA Adjustment
BUILDINGS	438,536	(12,692)	181,179	(5,529)
GARAGE	10,000		8,241	
LAND IMPR	20,000		16,470	
LAND	10,000	12,692	0	
EQUIPMENT	47,041		42,470	
VEHICLES	19,847		1,241	
TOTALS	545,424	0	249,601	(5,529)
BEGINNING ACCUM DEPR			235,957	5,106
DEPRECIATION EXPENSE			19,563	423
DISPOSITIONS			-5,919	
ENDING ACCUM DEPR			249,601	5,529
		variance	0	

FACILITY NAME:	**Allen Court**	**BEGINNING:**	**10/01/01**
ID#:	**0033571**	**ENDING:**	**09/30/02**

RECLASSIFICATION ENTRIES

	Schedule and Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1)				
To Reclass Meals To Employee Benefits				
Food Purchase	**V-2**	**31,529**	**(857)**	**30,672**
Employee Benefits & Payroll Taxes	**V-22**	**51,044**	**857**	**51,901**
(2)				
To Allocate a % of Vehicle Expenses To Program				
Program Transportation	**V-14**	**539**	**746**	**1,285**
Other Admin. Staff Transportation	**V-25**	**1,491**	**(746)**	**745**

FACILITY NAME: Allen Court BEGINNING: 10/01/01
ID #: 0033571 ENDING: 09/30/02

ATTACHED SCHEDULE I

VII. RELATED NURSING HOMES

	FACILITY NAME	CITY
	Allen Court	Clinton
	Beardstown Terrace	Beardstown
	Bellefontaine Place	Waterloo
	Braun's Terrace	Greenville
	Carthage Terrace	Carthage
	Curtiss Court	Springfield
	Davies Square	Pekin
	Douglas Terrace	Jacksonville
	Edwardsville Terrace	Edwardsville
	Effingham Terrace	Effingham
	Eisenhower Terrace	Jacksonville
	Freeburg Terrace	Freeburg
	Froelich House	Galesburg
	Gaines Mill Place	Springfield
	Glenwood Terrace	Springfield
	Hawthorne Terrace	Galesburg
	Highview Terrace	Paris
	Jacksonville Group Homes:	
	Anna Terrace	Jacksonville
	Campbell Court	Jacksonville
	LaFayette Terrace	Jacksonville
	Kepley House	Pittsfield
	Lawrence Place	Lincoln
	Lincoln Terrace	Lincoln
Pioneer Concepts, Inc.	Maple Terrace	Quincy
	Plonka Terrace	Galesburg
	Quincy Terrace	Quincy
	Schultz House	Danville
	Stevens House	Galesburg
	Tanner Place	Paris
	Taylor House	Springfield
	Thelma Terrace	Wood River
	Trulson House	Galesburg
	Vahle Terrace	Jerseyville
	Walsh Terrace	Galesburg
	Wetherell Place	Effingham
	Woodriver Group Homes:	
	Aberdeen Terrace	Alton
Pinnacle Opportunities, Inc.	Linton Terrace	Wood River
	Madison Terrace	Wood River
	Pershing Terrace	Wood River
	River Court	Kankakee
	Station Court	Kankakee
	Kankakee II Group Homes:	
	Eagle Court	Kankakee
	Kankakee Court	Kankakee
	Roy Court	Bourbonnais
Concepts Plus, Inc.		
	Lake County Group Homes:	
	Lewis Terrace	North Chicago
	Seymour Terrace	North Chicago
	Waukegan Terrace	Waukegan
	Pine Terrace	Waukegan

FACILITY NAME:	**Allen Court**	**BEGINNING:**	**10/01/01**
ID #:	**0033571**	**ENDING:**	**09/30/02**

ATTACHED SCHEDULE II **Bed Allocation**

1 FACLITY NAME: Allen Court BEGINNING: 10/01/01

ID#: 0033571 ENDING: 09/30/02

ATTACHED SCHEDULE III ALLOCATION OF HOME OFFICE INDIRECT COSTS

SUMMARY SCHEDULE

(See attached detail schedule)

Sch. V Line #		Salaries	Supplies	Other	Total
1	Dietary	347	18	0	365
2	Food Purchase			0	0
3	Housekeeping	0		0	0
4	Laundry			0	0
5	Heat & Other Utilities			0	0
6	Maintenance			0	0
7	Other			0	0
9	Medical Director			0	0
10	Nursing & Med Records			0	0
10A	Therapy			0	0
11	Activities			0	0
12	Social Services			0	0
13	Nurse Aide Training			0	0
14	Program Transportation			0	0
15	Other			0	0
17	Administrative	9,218		0	9,218
18	Directors Fees			368	368
19	Professional Services			1,254	1,254
20	Fees, Subs. & Pro.			129	129
21	Clerical & General	674		1,105	1,779
22	Employee Ben. & P/R			2,393	2,393
23	Inservice Training & Ed.			231	231
24	Travel & Seminar			652	652
25	Admin. Staff Transp.			293	293
26	Insurance			412	412
27	Other			0	0
30	Depreciation			397	397
31	Amortization of Pre-Op.			0	0
32	Interest			0	0
33	Real Estate Taxes			0	0
34	Rent-Facility & Grounds			110	110
35	Rent-Equip. & Vehicles			0	0
36	Other - Amortization			0	0
	TOTALS	10,239	18	7,344	17,601
	Salaries to be allocated to Scedule V, Column 1, Page 3 (Attached Sch. IV)				(10,239)
19	Amount per G/L - support services recorded as professional fees				(5,340)
	Net adjustment required				2,022

FACLITY NAME: Allen Court **BEGINNING:** 10/01/01

ID#: 0033571 **ENDING:** 09/30/02

ATTACHED SCHEDULE III **ALLOCATION OF INDIRECT COSTS**
(Detail Schedule)

Allocation Factors:

Support Services Factor		0.011486
Home Office Factor	**	0.029412

Schedule	Description		Total Expenses Incurred	Non-Allowable Costs	Costs To Be Allocated	Allocated Total	Adjustment Grouping
V-1-1	Labor - Dietary		30,247		30,247	347	347
V-1-2	Supplies - Dietary		1,609		1,609	18	18
V-3-1	Labor - Purchasing		0		0	0	0
V-17-1	Labor - Training		111,443		111,443	1,280	
V-17-1	Aide Training Income		0		0	0	
V-17-1	Labor - Maintenance		46,651		46,651	536	
V-17-1	Labor - Administrative	**	203,039		203,039	5,972	
V-17-1	Labor - Administrative		124,500		124,500	1,430	9,218
V-18-3	Board of Directors	**	15,781	3,257	12,524	368	368
V-19-3	Legal Fees		8,824		8,824	101	
V-19-3	Professional Services		100,400		100,400	1,153	1,254
V-20-3	Licenses/Fees/Misc		1,513		1,513	17	
V-20-3	Background Checks		36		36	0	
V-20-3	Advertising - Employment		86		86	1	
V-20-3	Subscriptions & Fees	**	3,765		3,765	111	129
V-21-1	Labor - Clerical		58,684		58,684	674	674
V-21-3	Supplies		45,068		45,068	518	
V-21-3	Miscellaneous		6,259		6,259	72	
V-21-3	Printing		3,082		3,082	35	
V-21-3	Postage & Shipping		869		869	10	
V-21-3	Equipment		11,966		11,966	137	
V-21-3	Equipment Contracts		1,464		1,464	17	
V-21-3	Equip Maintenance & Repair		0		0	0	
V-21-3	Telephone		27,490		27,490	316	1,105
V-22-3	Worker's Compensation		0		0	0	
V-22-3	Worker's Compensation	**	9,162		9,162	269	
V-22-3	Other Employee Expense		23,355		23,355	268	
V-22-3	FICA		15,532		15,532	178	
V-22-3	FICA	**	27,267		27,267	802	
V-22-3	State Unemployment Tax	**	10,237		10,237	301	
V-22-3	Health Insurance		27,024		27,024	310	
V-22-3	Health Insurance	**	9,008		9,008	265	2,393
V-23-3	Inservice Training		25,400	5,295	20,105	231	231
V-24-3	Travel	**	13,855		13,855	408	
V-24-3	Travel		21,220	0	21,220	244	
V-24-3	Seminar Training		0		0	0	652
V-25-3	Vehicle Expense		15,542		15,542	179	
V-25-3	Vehicle Expense	**	3,886		3,886	114	293
V-26-3	Vehicle Insurance		6,347		6,347	73	
V-26-3	Vehicle Insurance	**	6,346		6,346	187	
V-26-3	Property Insurance		13,235		13,235	152	412
V-30-3	Depreciation Expense		34,587		34,587	397	397
V-30-3	Depreciation Exp - Rental		80,951	80,951	0	0	
V-32-3	Admin Expense - Bonds		3,849	3,849	0	0	
V-32-3	Interest Expense		159,934	159,934	0	0	
V-32-3	Interest Expense - Rentals		118,514	118,514	0	0	
V-34-3	Rent		9,600		9,600	110	110
V-36-3	Amortization		32,777	32,777	0	0	
V-36-3	Amortization		504	504	0	0	
	Donations		5,952,017	5,952,017	0	0	
	TOTALS		7,422,925	6,357,098	1,065,827	17,601	17,601

FACILITY NAME: Allen Court
ID#: 0033571

BEGINNING: 10/01/01
ENDING: 09/30/02

ATTACHED SCHEDULE IV

The wage and salary expenses reported on Page 3, Schedule V, include both the amount directly related to the facility and the allocated salary and wages from the attached Schedule III. The following reconciliation presents the relationship among attached Schedule III, Schedule V on Page 3, Schedule XVII on Page 19, and Schedule XVIII Part A on Page 20.

Schedule V Line #		Per Facility Books	Allocated Att. Sch. III	Schedule V Column 1
	GENERAL SERVICES			
1	Dietary	36,823	347	37,170
3	Housekeeping	19,401	0	19,401
4	Laundry	0	0	0
6	Maintenance	5,017	0	5,017
	Total General Services	61,241	347	61,588
	HEALTH CARE & PROGRAMS			
10	Nursing and Medical Records	139,584	0	139,584
11	Activities	0	0	0
12	Social Services	0	0	0
13	Nurse Aid Training	5,336	0	5,336
	Total Health Care & Programs	144,920	0	144,920
	GENERAL ADMINISTRATION			
17	Administrative	9,449	9,218	18,667
21	Clerical & General Office Expenses	10,402	674	11,076
	Total General Administration	19,851	9,892	29,743
44	SPECIAL COST CENTERS	0	0	0
	TOTAL SALARIES	226,012	10,239	236,251
		Page 20, Sch XVIII Part A, Line 34		Page 4, Sch V Line 45, Col 1

SUMMARY	Total Costs Per Facility Books Page 19 Sch XVII	Total Costs Per Cost Report Page 4 Sch V,Col 4	Allocated Att. Sch. III Difference
Total General Services, Line 31 & Line 8	127,468	127,815	347
Total Health Care and Progams, Line 32 & Line 16	160,393	160,393	0
Total General Administration, Line 33 & Line 28	126,235	136,127	9,892
Total Ownership, Line 34 & Line 37	42,638	42,638	0
Total Special Cost Centers, Line 35 & Line 44	0	0	0
Provider Participation Fee, Line 36 & Line 42	34,511	34,511	0
GRAND TOTAL COSTS	491,245	501,484	10,239

FACILITY NAME: Allen Court
ID #: 0033571

BEGINNING: 10/01/01
ENDING: 09/30/02

ATTACHED SCHEDULE V

The difference between book and cost report for historical cost of assets and accumulated depreciation relates to the adjustment made by the IDPA after its desk audit for a prior period due to the change of ownership and the average land cost. Both book and cost report depreciation is calculated using the straight-line method. The following reconciliation presents the relationship between Schedule XI on Pages 11 to 13 and Schedule XV on Page 17.

HISTORICAL COST			Costs Per Facility's Books Sch XV	IDPA Adjusted Ownership Costs Sch XI	Difference
LINE # SCH XV	SCH XI				
	4	Buildings	438,536	425,844	12,692
	9	Garage	10,000	10,000	0
	10	Land Improvements	20,000	20,000	0
14	70	Total Buildings & Impr.	468,536	455,844	12,692
13	3	Land	10,000	22,692	(12,692)
		Subtotal of Land, Bldgs & Impr.	478,536	478,536	0
	75	Equipment	47,041	47,041	0
	80	Vehicle	19,847	19,847	0
16		Total Equipment	66,888	66,888	0
	81	Total Historical Cost	545,424	545,424	0

ACCUMULATED DEPRECIATION			Per Facility's Books Sch XV	Per Cost Report Sch XI	Difference
LINE # SCH XV	SCH XI				
	4	Buildings	181,179	175,650	5,529
	9	Garage	8,241	8,241	0
	10	Land Improvements	16,470	16,470	0
	70	Total Buildings & Impr.	205,890	200,361	5,529
	75	Equipment	42,470	42,470	0
	80	Vehicle	1,241	1,241	0
		Total Equipment	43,711	43,711	0
17	85	Total Accumulated Depreciation	249,601	244,072	5,529

DEPRECIATION RECONCILIATION	Per Facility's Books	Per Cost Report	Difference
Accumulated Depreciation, beginning	235,957	230,851	5,106
Depreciation Expense	19,563	19,140	423
Dispostions	-5,919	-5,919	0
Accumulated Depreciation, ending	249,601	244,072	5,529

FACILITY NAME: Allen Court BEGINNING: 10/01/01
ID#: 0033571 ENDING: 09/30/02

ATTACHED SCHEDULE VI

Some of the staff work two different jobs. They work one day as an aide, and the next as a cook or housekeeper. In all cases, there are other staff who are working as an aide to assist resident needs.

ATTACHED SCHEDULE VII

SCHEDULE XV - BALANCE SHEET

LINE 23 - OTHER:	
Loan Financing Costs	0
Leasehold Deposit	0
TOTAL	0

ATTACHED SCHEDULE VIII

SCHEDULE V - COST CENTER EXPENSES

LINE 27 - OTHER:	
Bad Debts	1
Lobbying	345
	346
LINE 36 - OTHER:	
Amortization	0
Less nonallowable amortization of goodwill	0
Home office allocation (attached schedule III)	0
	0

ATTACHED SCHEDULE IX

SCHEDULE VI - ADJUSTMENT DETAIL

LINE 29 - OTHER:		
Amortization of goodwill	V-36	0
Non-allowable out-of-state travel	V-24	0
Lobbying	V-27	345
Activity fund income	V-11	949
TOTAL		1,294

ATTACHED SCHEDULE X

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:	
Fuel and miscellaneous supplies	1,439
Repairs	52
	1,491

FACILITY NAME: Allen Court **BEGINNING** 10/01/01

ID#: 0033571 **ENDING:** 09/30/02

ATTACHED SCHEDULE XI

VII: RELATED PARTIES

Community Living Options, Inc - Board of Directors

Jack Crock
Howard Lehman
John Thompson
Jack Sandman
Mike Wartman
Bob Marshall

None of the Board members provide direct services to the nursing home, and none of the Board members have an ownership interest in an entity that conducts business with the nursing home.

Jack Crock is a stock brocker with A G Edwards & Sons, Inc. which provides investment services for Community Living Options, Inc.